

MDCH Chemical Event Epidemiologic Data Collection Form – Patient/Victim

Unique Case ID _____

Interviewer ID _____

Patient/Victim Information Section – Information to be collected applies to the patient/victim of the chemical incident.

LAST NAME _____

DOB/AGE
(DOB preferred) _____

RACE (Check one)
☐ White
☐ Black
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other

FIRST NAME _____

SEX
☐ Male
☐ Female
☐ Unk

WEIGHT

MIDDLE NAME _____

VICTIM CATEGORY (Check one)

- ☐ General Public
- ☐ Employee
- ☐ Student
- ☐ EMS/Prehospital
- ☐ Hospital Personnel
- ☐ Employee/industry responder
- ☐ Public health responder
- ☐ Responder (unspecified)
- ☐ Police officer
- ☐ Firefighter (unspecified)
- ☐ Volunteer firefighter

HAZMAT RESPONDER

- ☐ Yes
- ☐ No
- ☐ Unk

LANGUAGE

- ☐ English
- ☐ Other _____

ETHNICITY

- ☐ Non-Hispanic
- ☐ Hispanic

WEARING PPE

- ☐ Yes (indicate type below)
- ☐ No
- ☐ Unk

TYPE: (Check all that apply)

RESPIRATOR

- ☐ SCBA
- ☐ PAPR
- ☐ PAPR w/ escape SCBA

CLOTHING

- ☐ encapsulating chemical-protective suit
- ☐ hooded chemical-resistant clothing
- ☐ chemical-resistant overalls
- ☐ two-piece chemical-splash suit
- ☐ disposable chemical-resistant overalls
- ☐ nonresistant coveralls
- ☐ nonresistant work uniform

GLOVES

- ☐ outer chemical-resistant
- ☐ inner chemical-resistant

BOOTS

- ☐ boot covers-outer chemical-resistant
- ☐ boots/shoes chemical-resistant

Patient Contact Information

HOME ADDRESS

STREET _____

CITY _____ **COUNTY** _____ **ZIP** _____

HOME PHONE _____ **WORK PHONE** _____

EMPLOYER _____ **JOB DUTY** _____

WORK/JOBSITE ADDRESS

STREET _____

CITY _____ **COUNTY** _____ **ZIP** _____

Alternate Contact Information – For additional/follow-up information

FIRST NAME _____ **LAST NAME** _____

HOME ADDRESS
STREET _____

CITY _____ **COUNTY** _____ **ZIP** _____

HOME PHONE _____ **RELATIONSHIP TO VICTIM** _____

Patient/Victim Clinical History

MEDICAL INFORMATION

FROM (check all that apply) ☐ Victim ☐ Informant(s) ☐ Medical records review ☐ Healthcare provider ☐ Other (specify) _____

EXPOSURE RELATED SIGNS AND SYMPTOMS (Check the appropriate signs and symptoms)

Breathing or Respiratory

- ☐ Irritation of nose, airways
- ☐ Dry mouth
- ☐ Runny nose
- ☐ Nosebleed
- ☐ Sneezing
- ☐ Increase in breathing rate
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Respiratory arrest
- ☐ Laryngeal spasm
- ☐ Pulmonary edema
- ☐ Pulmonary infiltrate

Cough:

- ☐ hacking cough
- ☐ productive cough
- ☐ cough w/ foamy sputum

Skin

- ☐ Pink or red coloration

Irritation:

- ☐ burning
- ☐ itching
- ☐ Blisters
- ☐ Cyanosis

Neurological

- ☐ Dizziness
- ☐ Headache

- ☐ Decreased memory, concentration
- ☐ Confusion
- ☐ Altered mood (giddiness, anxiety)
- ☐ Intoxication
- ☐ Hallucination
- ☐ Sudden loss of consciousness
- ☐ Coma
- ☐ Cramping
- ☐ Muscle twitching/tremors
- ☐ Ataxia
- ☐ Convulsions
- ☐ Flaccid paralysis
- ☐ Copious/involuntary secretions
- ☐ Drooling
- ☐ Localized sweating

Eye or Vision

- ☐ Tearing
- ☐ Itchy
- ☐ Burning
- ☐ Conjunctivitis
- ☐ Corneal opacity
- ☐ Physical damage
- ☐ Constricted pupils
- ☐ Dilated pupils
- ☐ Fixed pupils
- ☐ Blurred/dim/lack of vision

Gastrointestinal

- ☐ Loss of appetite
- ☐ Nausea

- ☐ Vomiting
- ☐ Diarrhea

Cardiac

- ☐ Hypotension
- ☐ Palpitations
- ☐ Arrhythmia
- ☐ Chest pain
- ☐ Cardiac arrest

Immune

- ☐ Fever
- ☐ Neutropenia

Trauma (note others)

- ☐ Laceration
- ☐ Fracture
- ☐ Burn

OTHER SYMPTOMS, MEDICAL DX, TRAUMA (Describe)

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- " Victim was not decontaminated
- " Decontaminated on scene
- " Decontaminated at medical facility
- " Both on scene and at medical facility

ONSET OF IDENTIFIED SYMPTOMSDATE _____ HOUR _____ am
pm**DURATION OF**IDENTIFIED SYMPTOMS _____ days
weeks
months**FATAL ILLNESS** (Check one)

- " Yes
- " No
- " Unk

DATE OF

DEATH (If fatal) _____

RESIDUAL SYMPTOMS (Describe):**HEALTHCARE RECEIVED****TYPE** (Check one)

- " ED – outpatient
- " Hospital – inpatient
- " Urgent care facility
- " Private physician

TREATING PHYSICIAN

NAME _____

PHONE _____

FACILITY NAME _____**STREET ADDRESS** _____**CITY** _____ **STATE** _____**EXPOSURE SPECIFIC TREATMENT RECEIVED** (Describe):**Patient/Victim Laboratory Information and Case Status** – Laboratory information if gathered and available.**SPECIMEN 1****TYPE** (Check one)

- " Stool
- " Urine
- " Blood
- " Vomitus
- " Skin swab
- " CSF

LAB

NAME _____

SPECIMEN

NUMBER _____

DATE

COLLECTED _____

RESULT:**SPECIMEN 2****TYPE** (Check one)

- " Stool
- " Urine
- " Blood
- " Vomitus
- " Skin swab
- " CSF

LAB

NAME _____

SPECIMEN

NUMBER _____

DATE

COLLECTED _____

RESULT:**SPECIMEN 3****TYPE** (Check one)

- " Stool
- " Urine
- " Blood
- " Vomitus
- " Skin swab
- " CSF

LAB

NAME _____

SPECIMEN

NUMBER _____

DATE

COLLECTED _____

RESULT:**CASE STATUS** (Check one)

- " Confirmed case - A clinically compatible case with confirmatory laboratory results.
- " Presumptive case - A clinically compatible case with presumptive laboratory results.
- " Suspected case - A clinically compatible case without presumptive or confirmatory laboratory results.
- " Not a case

Patient/Victim Notes – Additional notes, narrative, or distinguishing characteristics about the victim or incident.**NOTES:**

Pre-existing conditions, Allergies, Medications:

Additional Cases - Persons in household presenting with similar symptoms.

FIRST NAME _____ LAST NAME _____ DATE OF ONSET _____

FIRST NAME _____ LAST NAME _____ DATE OF ONSET _____

FIRST NAME _____ LAST NAME _____ DATE OF ONSET _____

CONFIDENTIAL DATA**(End of Patient/Victim Form)**

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Victim Specific Event Information

NUMBER OR DESCRIPTION OF ASSOCIATED EVENT

DESCRIPTION (If event number unknown)

EVENT NUMBER _____ (county code - year - event)

VICTIM'S LOCATION AND PRECAUTIONS

VICTIM PROXIMITY TO RELEASE POINT (Check one)

- " Immediate area where release occurred/<10 ft
- " Wing/section of building/11-50 ft
- " Building/51-100 ft
- " Facility/101 - 200 ft
- " 200ft - 1/4 mi
- " 1/4 mi - 1/2 mi
- " 1/2 mi - 1 mi
- " >1 mi
- " Unknown release point
- " Unknown location at time of release

VICTIM LOCATION

AT TIME OF RELEASE (Check one)

- " Outside
- " Home
- " In vehicle
- " Commercial building
- " Industrial building
- " Other (specify) _____
- " Unknown release point
- " Unknown location at time of release

PRECAUTIONS TAKEN

(Check all that apply)

- " None
- " Ventilation shut down
- " Shelter in place
- " PPE
- " Unknown
- " Other (specify) _____

NOTES (Additional details about proximity, environment and precautions)

Victim Exposure to Substance

PHYSICAL STATE
OF SUBSTANCE

- " Powder
- " Gas
- " Liquid
- " Solid
- " Aerosol
- " Unknown

ROUTE OF EXPOSURE

(Check all that apply)

- " Skin
- " Inhalation
- " Ingestion
- " Injection
- " No direct contact
- " Unknown

ESTIMATED DURATION OF EXPOSURE

Sec
min
hour(s)
day(s)INFORMATION OR INSTRUCTIONS
PROVIDED POST-EXPOSURE

- " Fact sheet
- " Verbal instructions
- " Sought own information
- " None

ENVIRONMENTAL SAMPLES TO DOCUMENT EXPOSURE (If yes, document type and result)

- " Yes
- " No
- " Unk

ENVIRONMENTAL SAMPLE 1

DATE _____

LOCATION _____

TYPE _____

RESULT:

ENVIRONMENTAL SAMPLE 2

DATE _____

LOCATION _____

TYPE _____

RESULT:

ENVIRONMENTAL SAMPLE 3

DATE _____

LOCATION _____

TYPE _____

RESULT:

NOTES (Additional event, exposure or environmental sampling information)